

Multimedia Appendix

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Biweekly survey- Intervention arm

Section title- Recent Illnesses

1. *Since completing the last survey have any household members developed a NEW respiratory illness, such as the flu, a cold, a sinus infection, or bronchitis? If so, what symptoms have they had? Please check the appropriate boxes.*

*If no one has been sick with the flu, a cold, or other respiratory infection, skip to **Section 2**.*

<u>Household Member</u>	<u>Illness</u>	<u>Symptoms</u>	
1. You	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> fever <input type="checkbox"/> cough <input type="checkbox"/> sore throat <input type="checkbox"/> muscle aches <input type="checkbox"/> headache	<input type="checkbox"/> runny nose <input type="checkbox"/> stuffy nose <input type="checkbox"/> fatigue <input type="checkbox"/> breathing difficulty <input type="checkbox"/> voice hoarseness
2. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> fever <input type="checkbox"/> cough <input type="checkbox"/> sore throat <input type="checkbox"/> muscle aches <input type="checkbox"/> headache	<input type="checkbox"/> runny nose <input type="checkbox"/> stuffy nose <input type="checkbox"/> fatigue <input type="checkbox"/> breathing difficulty <input type="checkbox"/> voice hoarseness
3. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> fever <input type="checkbox"/> cough <input type="checkbox"/> sore throat <input type="checkbox"/> muscle aches <input type="checkbox"/> headache	<input type="checkbox"/> runny nose <input type="checkbox"/> stuffy nose <input type="checkbox"/> fatigue <input type="checkbox"/> breathing difficulty <input type="checkbox"/> voice hoarseness
4. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> fever <input type="checkbox"/> cough <input type="checkbox"/> sore throat <input type="checkbox"/> muscle aches <input type="checkbox"/> headache	<input type="checkbox"/> runny nose <input type="checkbox"/> stuffy nose <input type="checkbox"/> fatigue <input type="checkbox"/> breathing difficulty <input type="checkbox"/> voice hoarseness
5. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> fever <input type="checkbox"/> cough <input type="checkbox"/> sore throat <input type="checkbox"/> muscle aches <input type="checkbox"/> headache	<input type="checkbox"/> runny nose <input type="checkbox"/> stuffy nose <input type="checkbox"/> fatigue <input type="checkbox"/> breathing difficulty <input type="checkbox"/> voice hoarseness

2. Did any of the household members who were sick with a respiratory illness take medications? If yes, (1) were any of them prescription medications, and (2) which medications did they take? Please check **all** that apply.

<u>Household Member</u>	<u>Med?</u>	<u>Rx?</u>	<u>Medications used</u>
1.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tylenol or Ibuprofen (includes Motrin, Advil, and Aleve) <input type="checkbox"/> over the counter cough or cold medication <input type="checkbox"/> antibiotic <input type="checkbox"/> anti-influenza agent <input type="checkbox"/> other: _____
2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tylenol or Ibuprofen (includes Motrin, Advil, and Aleve) <input type="checkbox"/> over the counter cough or cold medication <input type="checkbox"/> antibiotic <input type="checkbox"/> anti-influenza agent <input type="checkbox"/> other: _____
3.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tylenol or Ibuprofen (includes Motrin, Advil, and Aleve) <input type="checkbox"/> over the counter cough or cold medication <input type="checkbox"/> antibiotic <input type="checkbox"/> anti-influenza agent <input type="checkbox"/> other: _____
4.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tylenol or Ibuprofen (includes Motrin, Advil, and Aleve) <input type="checkbox"/> over the counter cough or cold medication <input type="checkbox"/> antibiotic <input type="checkbox"/> anti-influenza agent <input type="checkbox"/> other: _____
5.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Tylenol or Ibuprofen (includes Motrin, Advil, and Aleve) <input type="checkbox"/> over the counter cough or cold medication <input type="checkbox"/> antibiotic <input type="checkbox"/> anti-influenza agent <input type="checkbox"/> other: _____

3. *Did they have to see or speak with a healthcare provider because of the respiratory illness?*

Household
Member

Healthcare use

- | | | |
|----|---|---|
| 1. | <input type="checkbox"/> Yes
<input type="checkbox"/> No | <input type="checkbox"/> saw doctor in primary care clinic
<input type="checkbox"/> called doctor or nurse
<input type="checkbox"/> seen in the ER
<input type="checkbox"/> admitted to hospital
<input type="checkbox"/> saw doctor in specialty clinic
<input type="checkbox"/> other: _____ |
| 2. | <input type="checkbox"/> Yes
<input type="checkbox"/> No | <input type="checkbox"/> saw doctor in primary care clinic
<input type="checkbox"/> called doctor or nurse
<input type="checkbox"/> seen in the ER
<input type="checkbox"/> admitted to hospital
<input type="checkbox"/> saw doctor in specialty clinic
<input type="checkbox"/> other: _____ |
| 3. | <input type="checkbox"/> Yes
<input type="checkbox"/> No | <input type="checkbox"/> saw doctor in primary care clinic
<input type="checkbox"/> called doctor or nurse
<input type="checkbox"/> seen in the ER
<input type="checkbox"/> admitted to hospital
<input type="checkbox"/> saw doctor in specialty clinic
<input type="checkbox"/> other: _____ |
| 4. | <input type="checkbox"/> Yes
<input type="checkbox"/> No | <input type="checkbox"/> saw primary care doctor in clinic
<input type="checkbox"/> called doctor or nurse
<input type="checkbox"/> seen in the ER
<input type="checkbox"/> admitted to hospital
<input type="checkbox"/> saw doctor in specialty clinic
<input type="checkbox"/> other: _____ |
| 5. | <input type="checkbox"/> Yes
<input type="checkbox"/> No | <input type="checkbox"/> saw primary care doctor in clinic
<input type="checkbox"/> called doctor or nurse
<input type="checkbox"/> seen in the ER
<input type="checkbox"/> admitted to hospital
<input type="checkbox"/> saw doctor in specialty clinic
<input type="checkbox"/> other: _____ |

3a. [If yes for question 3; ask for each household member who saw a physician]
Did you/household member get a flu test?

- ☐ Yes
☐ No

3b. [If yes to question 1a; ask for each household member who got the test]
What was the result of the test?

- ☐ positive for the flu
☐ negative for the flu
☐ don't know

4. [Ask for every household member who was sick]

For how many days did the respiratory illness last from beginning to end?

- Number of days: ☐ don't know yet, the illness is still present
 ☐ 1, 2, 3, 4, etc to 14

5. *Did any of the household members who were sick with a respiratory illness have to miss work, school, or daycare because they were sick? Did any household members have to miss work or school to take care of another household member sick with a respiratory illness? Please check the appropriate boxes.*

<u>Household Member</u>	<u>Missed Due to Illness</u>	<u>Missed Due to Sick family member</u>
1.	<input type="checkbox"/> work; # of days: _____	<input type="checkbox"/> work; # of days: _____
2.	<input type="checkbox"/> work; # of days: _____ <input type="checkbox"/> school; # of days: _____ <input type="checkbox"/> daycare; # of days: _____	<input type="checkbox"/> work; # of days: _____ <input type="checkbox"/> school; # of days: _____
3.	<input type="checkbox"/> work; # of days: _____ <input type="checkbox"/> school; # of days: _____ <input type="checkbox"/> daycare; # of days: _____	<input type="checkbox"/> work; # of days: _____ <input type="checkbox"/> school; # of days: _____
4.	<input type="checkbox"/> work; # of days: _____ <input type="checkbox"/> school; # of days: _____ <input type="checkbox"/> daycare; # of days: _____	<input type="checkbox"/> work; # of days: _____ <input type="checkbox"/> school; # of days: _____
5.	<input type="checkbox"/> work; # of days: _____ <input type="checkbox"/> school; # of days: _____ <input type="checkbox"/> daycare; # of days: _____	<input type="checkbox"/> work; # of days: _____ <input type="checkbox"/> school; # of days: _____

6. [Ask for subject only]

How many days did you attend work despite feeling sick from the respiratory illness?

Number: _____

7. *During the past 2 weeks have you been sick with an illness other than a respiratory illness?*

- ☐ Yes
☐ No

If so, did you miss any days of work because of this illness?

- ☐ Yes; # of days: _____
☐ No

Section title- Flu shot

1. [Ask for household members who have not yet gotten the flu shot, including the subject] *Since completing the last survey, have you/ household members received the flu shot?*

- ☐ Yes. Household member number(s): _____
- ☐ No

2. [Ask for subject and every household member if received vaccine]

Where did you/household member get the flu shot?

- ☐ A doctor's office or health maintenance organization
- ☐ A health department
- ☐ Another type of clinic or health center
- ☐ A senior, recreation, or community center
- ☐ A store
- ☐ A hospital or emergency room
- ☐ Workplace